

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 11 Film 408  
1/14/69 kb  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
18293  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18296

1. DECEASED-NAME (Type or Print) First Middle Last <b>Rodney Adams</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>Dec. 27 1968</b>			2b. HOUR M <b>9:30 A.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>Aug. 12, 1968</b>		6. AGE (In years last birthday) YRS. <b>4</b>		7c. DATE PRONOUNCED DEAD Month Day Year <b>Dec. 27 1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Somerset Md.</b>				
10. CITY OR TOWN OF DEATH <b>Westover</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Box 171, Rehobeth Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>914 N. Fremont Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Butler</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Nancy Adams</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Nancy Adams</b>			17. ADDRESS <b>914 N. Fremont Ave. Baltimore, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>795 X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Crib death</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>unknown</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>7952</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>C. G. Rawley</b>			M.D. <b>C. G. Rawley, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Dec. 30, 1968</b>	
EXAMINER'S NAME (Type) <b>C. G. Rawley, M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>Crisfield, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Private Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Rehobeth Som. Md.</b>		
24. FUNERAL DIRECTOR <b>Anthony E. Ward</b>			ADDRESS <b>Crisfield, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 6 1969</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M. REV. 1-54

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
18284 CERTIFICATE OF DEATH 18297													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
JOHN LOUIS CHAMBERLIN						December 9, 1968			10 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White		March 17, 1896			72 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			U.S.A.						SOMERSET			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Westover			R.F.D. 1			Heavy Equip. Oper.			State Roads				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
Maryland			Somerset			Westover			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.F.D. 1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Franklin R. Chamberlin			Sarah Elizabeth Long										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
no			218-12-1373			Mrs May W. Chamberlin,			Westover, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Acute dx of Heart Coronary Embolus</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic dx of heart disease</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>General arterio sclerosis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
592X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
mm						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			no			Street or R.F.D. No.			County				
									State				
22a. I certify that (I) (this hospital) attended the deceased from <u>October 1, 1967</u> , to <u>Dec 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE									22c. DATE SIGNED				
<u>George C. Coulbourn</u>													
22d. PHYSICIAN'S NAME (Type)									22e. ADDRESS				
George C. Coulbourn, M.D.									Marion, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town) (County) (State)				
Burial			12-11-1968			St. Paul Cemetery			Marion-Somerset-Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Robert H. Watson						DATE			DEC 16 1968				
Pocomoke City, Md.									J. Charles Judge				

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18285										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18298									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last <b>Dennis Robert Cooper</b>										Month Day Year <b>12 17 68</b>										Hour Minute <b>6:30 PM</b>									
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Dec. 16, 1968</b>			6. AGE (In years last birthday) <b>No</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS <b>No</b>			IF UNDER 24 HRS. HOURS MIN. <b>No</b>														
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Somerset</b>																				
10. CITY OR TOWN OF DEATH <b>Crisfield</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>McCready Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Somerset</b>			13c. CITY OR TOWN <b>Crisfield</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>RFD #1, Box 35</b>																	
14. FATHER'S NAME First Middle Last <b>Dennis - Cooper</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Deborah - Tawes</b>																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>Dennis Cooper, Same as 13. abcde</b>																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7777X</b> <u>Chromatury</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24h</b>																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>776X</b>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>19</b>			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M.</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <b>19</b>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (1) this hospital attended the deceased from <b>12-16, 1968</b> , to <b>12-17, 1968</b> , that (1) (we) lost saw the deceased alive on <b>12-17-68</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>James A. Sterling M.D.</b>										22c. DATE SIGNED <b>12-18-68</b>			22d. PHYSICIAN'S NAME (Type) <b>James A. Sterling M.D.</b>		22e. ADDRESS <b>Crisfield, Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec 18, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Somerset, Md.</b>																				
24. FUNERAL DIRECTOR ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Md. 21817</b>						25a. REC'D BY REGISTRAR <b>12-13-1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>																				

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18296										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18299																								
Perry James Cooper										CERTIFICATE OF DEATH																																		
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR																													
Infant Male Cooper										12/16/68					10:35 AM																													
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS																			
Male					White					12-17-68					No					No					5 1/2																			
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH																													
Maryland					USA										Somerset					Md.																								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																													
Crisfield					McCreedy Hospital					None					None																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER																								
Maryland					Somerset					Crisfield					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					RFD #1, Box 35																								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																																							
First Middle Last					First Middle Last																																							
Dennis - Cooper					Deborah Tawes																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address																													
No					None					None					Dennis Cooper, Same as 13.					abcde																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY:																																												
IMMEDIATE CAUSE (a) <i>Pulmonary insufficiency</i>															7-12 hours																													
776.9																																												
DUE TO, OR AS A CONSEQUENCE OF																																												
(b) <i>Chromatury</i>																																												
DUE TO, OR AS A CONSEQUENCE OF																																												
(c)																																												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																												
7625																																												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																		
					HOUR A.M. Month Day Year																																							
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No.					City or Town					County					State														
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>															16.					No.																								
22a. I certify that (I) (this hospital) attended the deceased from <i>12-17-68</i> , 19 <i>68</i> , to <i>12-17-68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-16-68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.																																												
22b. SIGNATURE															22c. DATE SIGNED																													
<i>J. A. Sterling M.D.</i>															12-18-68																													
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS																													
J. A. Sterling, M.D.															Crisfield, Md.																													
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)																													
Burial					Dec 18, 1968					Sunnyridge Cemetery					Crisfield, Somerset, Md.																													
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR															25b. REGISTRAR'S SIGNATURE														
ADDRESS															DEC 23 1968																													
Bradshaw & Sons, Crisfield, Md. 21817																																												

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<div>18237</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18300</div>														
1. DECEASED-NAME (Type or print)			First LEVIN		Middle E.		Last ELLIOTT		2a. DATE OF DEATH Month Day Year Dec. 25, 1968			2b. HOUR ? M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH Aug. 12, 1903			6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Delaware			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Somerset Md.					
10. CITY OR TOWN OF DEATH Marion Station			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RFD #1, Box 492			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Poultry Grower			12b. KIND OF BUSINESS OR INDUSTRY Poultry					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Somerset			13c. CITY OR TOWN Marion			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD #1, Box 492			
14. FATHER'S NAME First Middle Last Henry - Elliott			15. MOTHER'S MAIDEN NAME First Middle Last Julia <del>MESSICK</del> - Messick											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) NONE 217-30-7588			17. INFORMANT Mrs. Thelma Elliott, Same as 13. abcde								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute self of heart</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio Sclerotic Heart Embolus</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 <u>General Arterio Sclerosis</u>														
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <u>no accident</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) None			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 25, 1968</u> , to <u>Dec 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>George C. Coulbourn MD</u> DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS. PHYS.												22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) George C. Coulbourn, M. D.			22e. ADDRESS Marion Station, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Dec. 28, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery			23d. LOCATION (City or Town) (County) (State) Marion Station, Somerset, Md.					
24. FUNERAL DIRECTOR ADDRESS Bradshaw & Sons, Crisfield, Md. 21817						25a. REC'D BY REGISTRAR DATE DEC 31 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

00582

DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON

1918

NOV 15

TO

THE SECRETARY

FROM

NOV 15

REPLY

REPLY

TO

THE SECRETARY

FROM

REPLY

NOV 15 1918

NOV 15 1918

NOV 15 1918

TO

THE SECRETARY

FROM

REPLY

NOV 15 1918

DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON

1918

NOV 15

NOV 15 1918

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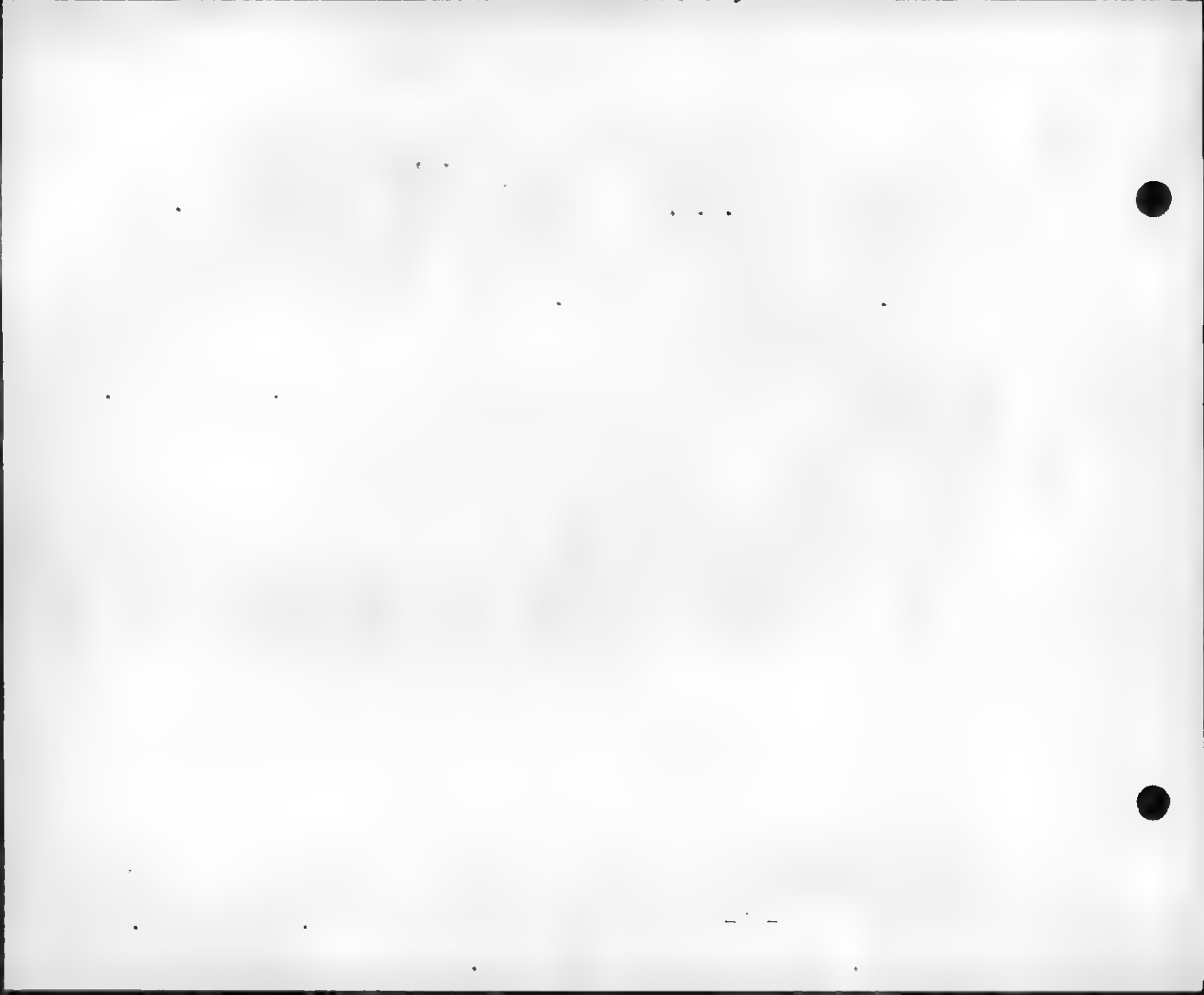
NOV 15 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A  
45M

18233										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18301				
Item 1 Film 408 1/14/69 kk										CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print) Roland <del>Richard</del> NEWMAN					First Middle Last Horner					2a. DATE OF DEATH 12 Month 15 Day 68 Year					2b. HOUR 7:30 M									
3. SEX Male					4. RACE White					5. DATE OF BIRTH FEB. 5, 1887					6. AGE (In years last birthday) 81 YRS.					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) MARYLAND					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH SOMERSET CO.					Md				
10. CITY OR TOWN OF DEATH Orisfield					11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Orisfield					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED WATERMAN					12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) MD.					13b. COUNTY SOMERSET					13c. CITY OR TOWN MT. VERNON					13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER				
14. FATHER'S NAME First Middle Last JOHN HORNER					15. MOTHER'S MAIDEN NAME First Middle Last ANNIE COX																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address MR. EMMONS HORNER, MT. VERNON, MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>25 years</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Malnutrition</u>																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>12-12-1968</u> to <u>12-15-1968</u> , that (I) (we) last saw the deceased alive on <u>12/15/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>James A. Sterling M.D.</u>					22c. DATE SIGNED <u>12-15-68</u>					22d. PHYSICIAN'S NAME (Type) James A. Sterling, M.D.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 12-17-1968					23c. NAME OF CEMETERY OR CREMATORY ASBURY CEMETERY					23d. LOCATION (City or Town) (County) (State) MT. VERNON, MD.									
24. FUNERAL DIRECTOR ADDRESS LEVIN R. WILSON PRINCESS ANNE, MD.					25a. REC'D BY REGISTRAR DATE DEC 23 1968					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>														



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

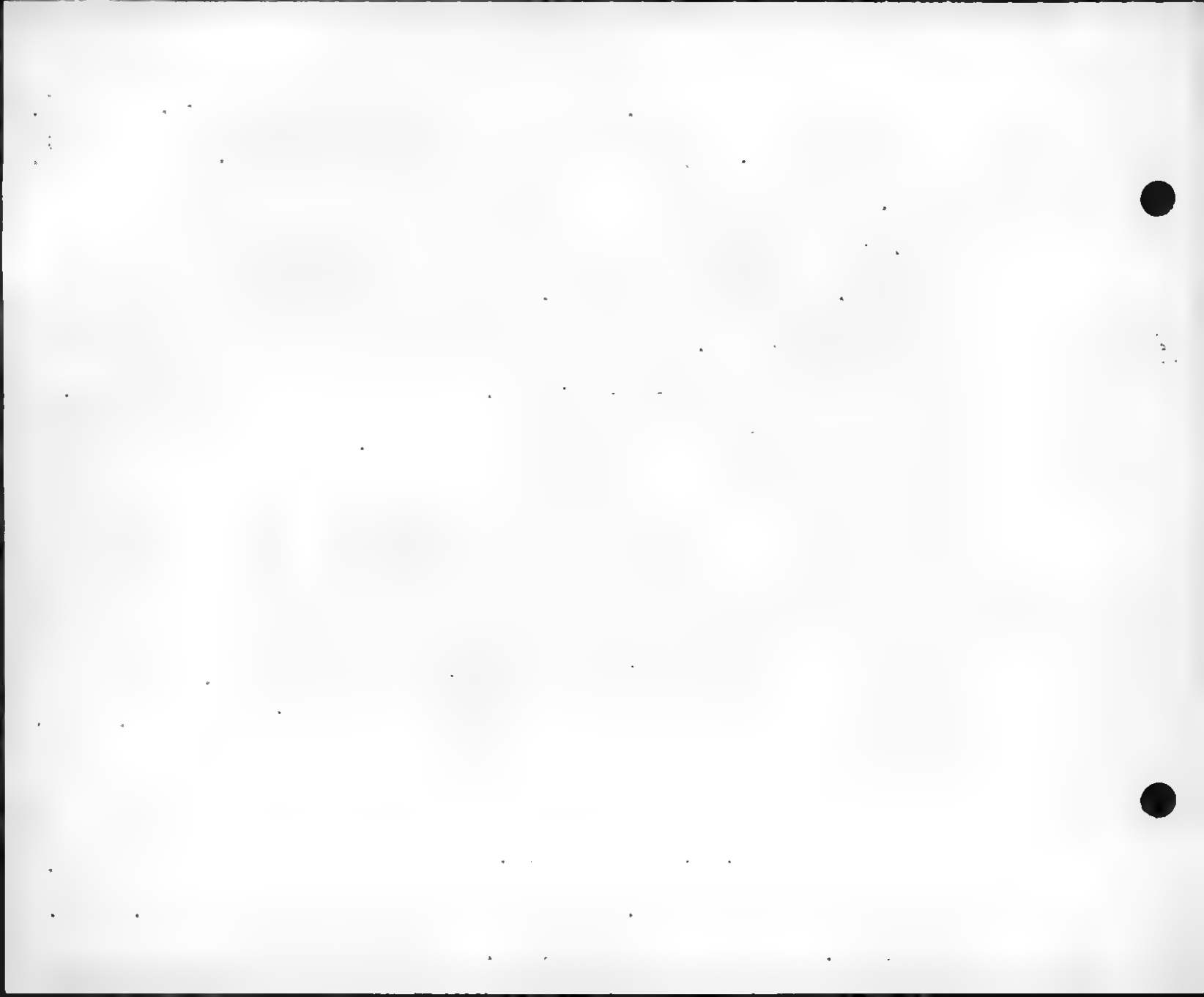
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18283

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

18302

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR OF DEATH		
JOHN			H.			KING			Dec. 10 1968			9:30 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR OF DEATH			
Male	Negro	Feb. 19, 1884	84 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			9:30 A.M.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH					
Md.			USA			WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Somerset			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
(Rural) Marion						Laborer								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Somerset			Pr. Anne			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
First Middle Last			First Middle Last			(Yes, no, or unknown) (If yes give war or dates of service)			214-12-6796			Mrs. Nettie Miles Oakville, Md.		
Littleton M. King			Henrietta Anderson											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED IMMEDIATELY BY												Minutes		
Sub- Total consumption by fire.														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
916C														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		
7 12/10/19 68			7 12/10/19 68			Overcome by smoke inhalation and flame due to house fire.			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			Home		
									(Rural) Marion			Som. Md.		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		
ACTUAL SIGNATURE			C. G. Rawley.			M.D.			22b. DATE SIGNED			12/12/68		
EXAMINER'S NAME (Type)			C. G. Rawley, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)			Crisfield, Md.		
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			12/14/68			St. Marks Cemetery			Oakville Som. Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG. STRAR			25b. REG. STRAR'S SIGNATURE					
Charles H. Ward			Marion, Md.			DEC 16 1968			Charles Judge					



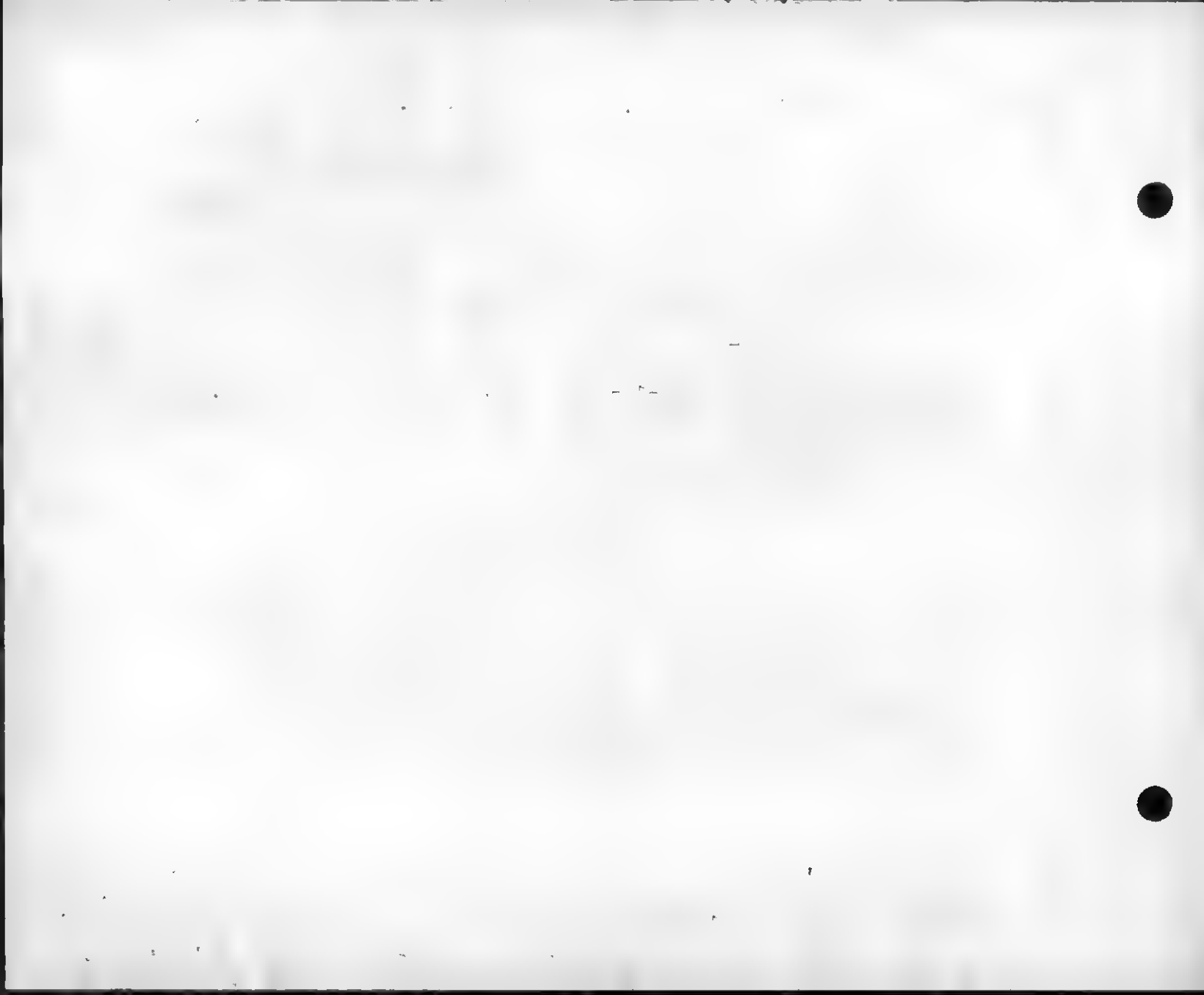


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

18290		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				18303	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)		First		Middle		Last	
Allie		G.		Lee, Sr.			
2a DATE OF DEATH		Month		Day		Year	
Dec.		19		38		10 <sup>P</sup> M	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		7b HOUR
Male	White		March 18, 1909		59 YRS		10 <sup>P</sup> M
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Virginia	USA				Somerset Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Crisfield		McCready Hospital		Waterman		USA	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Somerset		Crisfield		Gandy Lane	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)		16b SOCIAL SECURITY NO.	
Rome		Pearl		Yes		229-12-4505	
17 INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		17 ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Agnes Lee, Same as 13. abcde		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>				24 hr.	
		(b) <u>4369</u>					
		DUE TO, OR AS A CONSEQUENCE OF					
		(c)					
		DUE TO, OR AS A CONSEQUENCE OF					
		(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
2							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>12/19/68</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
H. C. Kaufman				H. C. Kaufman, M.D.			
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
Crisfield, Md.				Crisfield, Md.			
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Dec. 22, 1968		American Legion		Crisfield, Somerset, Md.	
24. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	
Bradshaw & Sons, Crisfield, Md. 21817		DATE DEC 27 1968		Charles Judge			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1d. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner. Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18291

18304

1. DECEASED NAME (Type or Print)			First <b>ROY</b>			Middle <b>C.</b>			Last <b>MILBOURNE</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>Dec 30 1968</b>			2b. HOUR <b>2 A M</b>	
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 20, 1916</b>		6. AGE (In years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>Dec 30 1968</b>			2d. HOUR <b>2 A M</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Somerset</b> Md.				
10. CITY OR TOWN OF DEATH <b>Crisfield</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>McCreedy Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Waterman</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Somerset</b>				13c. CITY OR TOWN <b>Crisfield</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>37 E. Chesapeake Ave. Ext.</b>				
14. FATHER'S NAME First Middle Last <b>Elwood Milbourne</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Geneva - Daugherty</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>				16b. SOCIAL SECURITY NO <b>213-22-5980</b>				17. INFORMANT ADDRESS <b>Mrs. Eloise Milbourne, Same as 13. abcde</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7. . . . .</b>																
19a. DATE OF OPERATION <b>7. . . . .</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <b>C. G. Rawley</b> EXAMINER'S NAME (Type) <b>C. G. Rawley, M. D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county) <b>Crisfield, Md.</b>						22b. DATE SIGNED <b>Dec. 31, 1968</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>Jan 1, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Somerset, Md.</b>						
24. FUNERAL DIRECTOR ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Md. 21817</b>										25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms 1, 2, and 3. 5 may be retained for your files.

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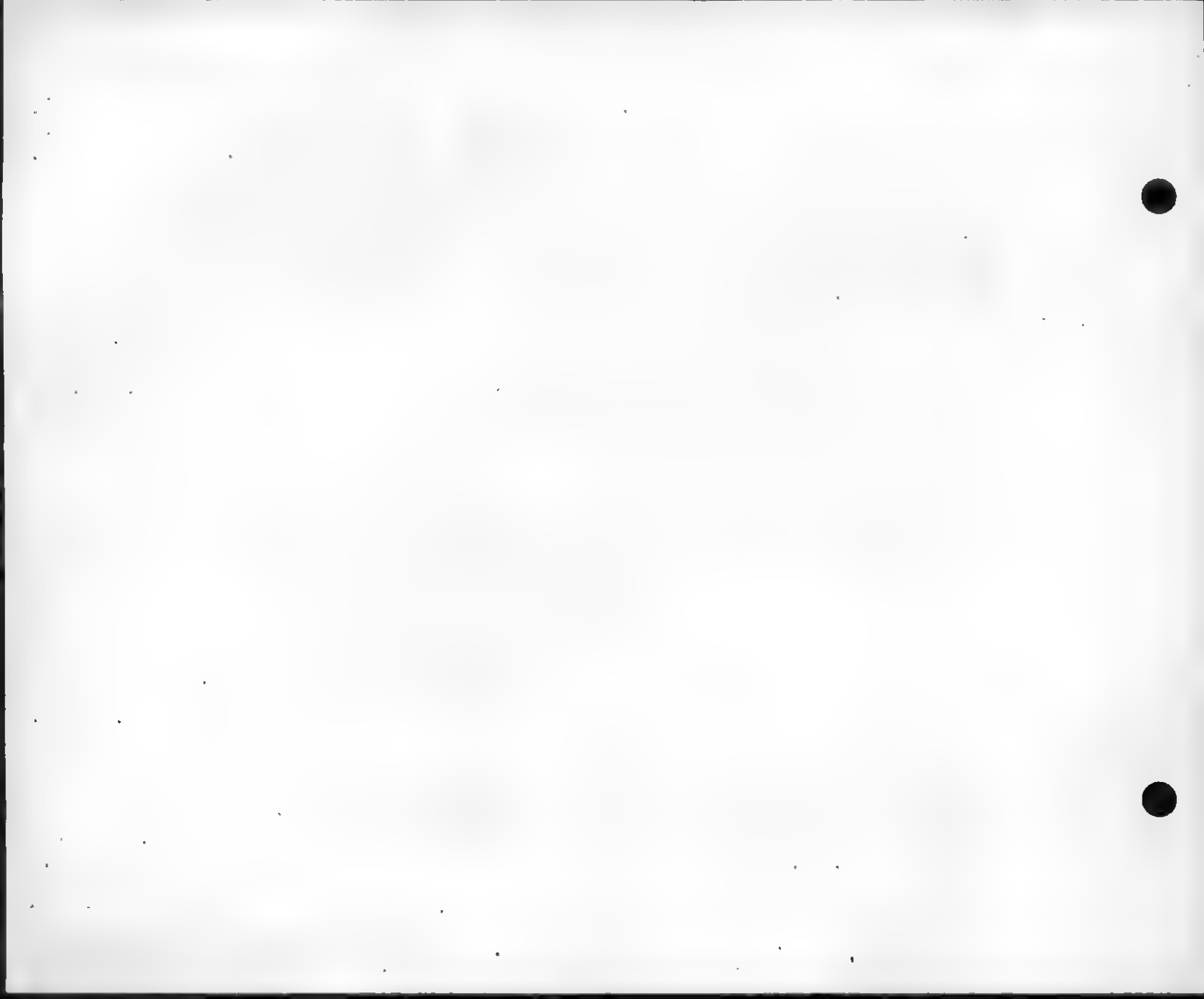
18202

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18305

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		EST - <input checked="" type="checkbox"/> Month Day Year		2b. HOUR OF DEATH	
FRANKIE		W.		MOORE				Dec. 10 1968				7:30 A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		F UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR OF DEATH	
Male	Negro	1934		34 YRS		MONTHS DAYS		HOURS MIN		Month Dec. Day 10 Year 1968		8:30 A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH							
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Somerset						Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
(Rural) Marion						None							
13a. USJA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY - M IS?		13e. STREET AND NUMBER					
Md.		Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle Last	
Zorah		Moore						Katie		Furr			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
No				William Moore		Baltimore, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY Sub-Total consumption by fire.												Minutes	
IMMEDIATE CAUSE (a)													
890X DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOJR A.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				7 PM 12/10/1968				Overcome by smoke inhalation and flame due to house fire.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or R.F.D. No City or Town County State					
				Home				(Rural) Marion Som. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				C. G. Rawley				M D					
EXAMINER'S NAME (Type)				C. G. Rawley				22b. DATE SIGNED					
								Dec. 12, 1968					
								ADDRESS (Street, city, town, or county)					
								Crisfield, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				12/14/68				Green Acres Memo. Cem					
								23d. LOCATION (City or Town) (County) (State)					
								Salisbury, Wicom., Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR					
Booker M. West				Salisbury, Md.				DATE DEC 18 1968					
								25b. REGISTRAR'S SIGNATURE					
								Charles Judge					

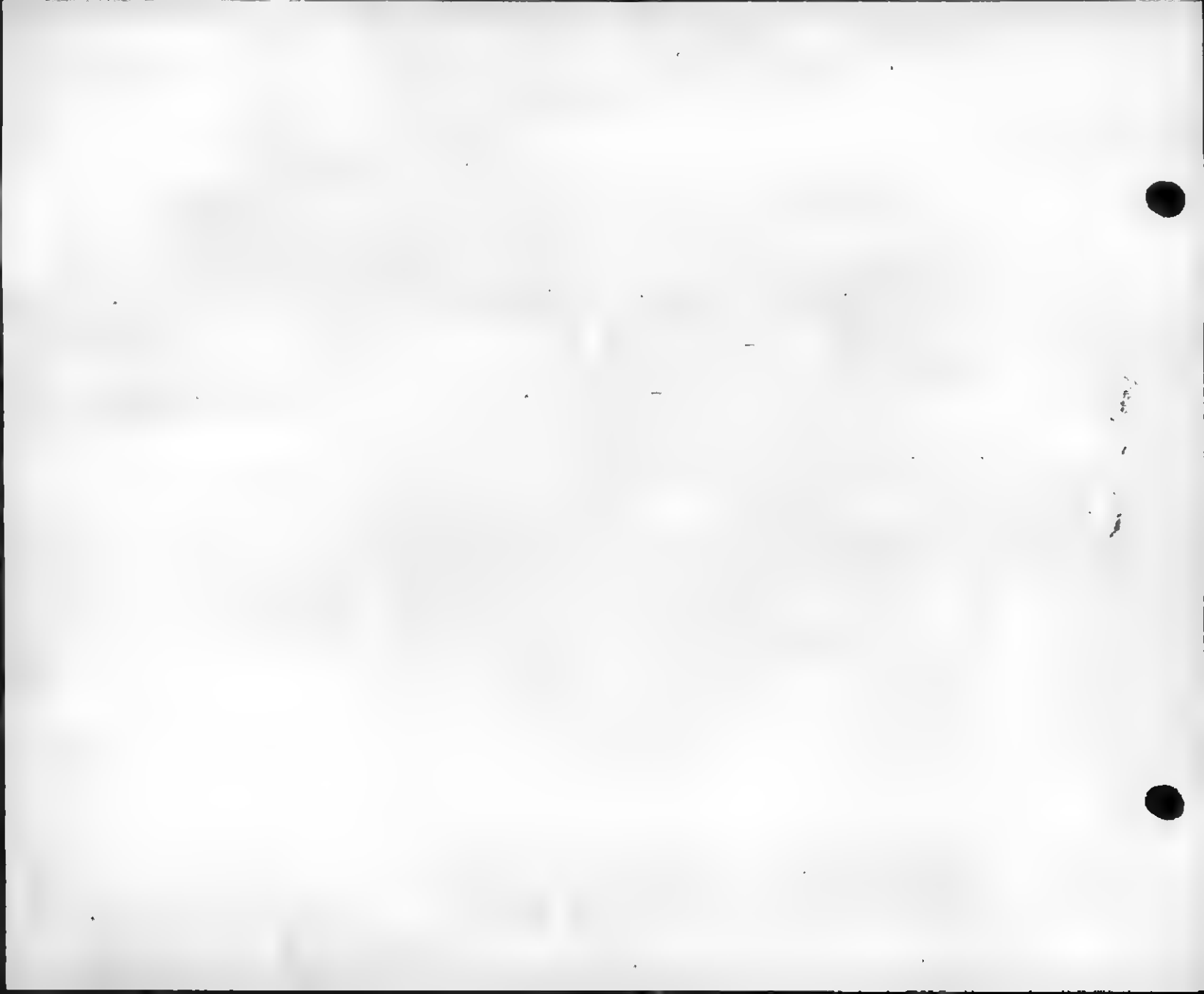




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18293												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
(F. Gwendolyn Nelson)												18306											
1. DECEASED-NAME (Type or print) First Middle Last												2a. DATE OF DEATH											
Nelson												Dec 10, 1968											
3 SEX												2b. HOUR A											
Female												12 Month 10 Day Year 68 5:45 M											
4 RACE												5 DATE OF BIRTH											
White												Aug 10, 1909											
7a. BIRTHPLACE (State or foreign country)												8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
Rhode Island												9. COUNTY OF DEATH											
USA												Somerset Md											
10 CITY OR TOWN OF DEATH												11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)											
Crisfield												Housewife											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE												12b. KIND OF BUSINESS OR INDUSTRY											
Maryland												None											
13b. COUNTY												13c. STREET AND NUMBER											
Somerset												119 Richardson Ave.											
14. FATHER'S NAME First Middle Last												15. MOTHER'S MAIDEN NAME First Middle Last											
James - Bennett												Elata - Hill											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)												16b. SOCIAL SECURITY NO											
No												217-16-9259											
17. INFORMANT												Address											
G. Solomon Nelson, Same as 13. abcde																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u>																							
746.4 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																							
DUE TO, OR AS A CONSEQUENCE OF (b)																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC											
21f. LOCATION Street or R.F.D. No City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 10, 1968</u> , to <u>Dec. 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>no</u>																							
22b. SIGNATURE <u>Sarah M. Peyton</u>												22c. DATE SIGNED <u>Dec. 10, 1968</u>											
22d. PHYSICIAN'S NAME (Type) <u>S. M. Peyton, M.D.</u>												22e. ADDRESS <u>Crisfield, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE											
Burial												Dec 12, 1968											
23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City or Town) (County) (State)											
Sunnyridge Cemetery												Crisfield, Somerset, Md.											
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR											
Bradshaw & Sons, Crisfield, Md. 21817												DEC 16 1968											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																							



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

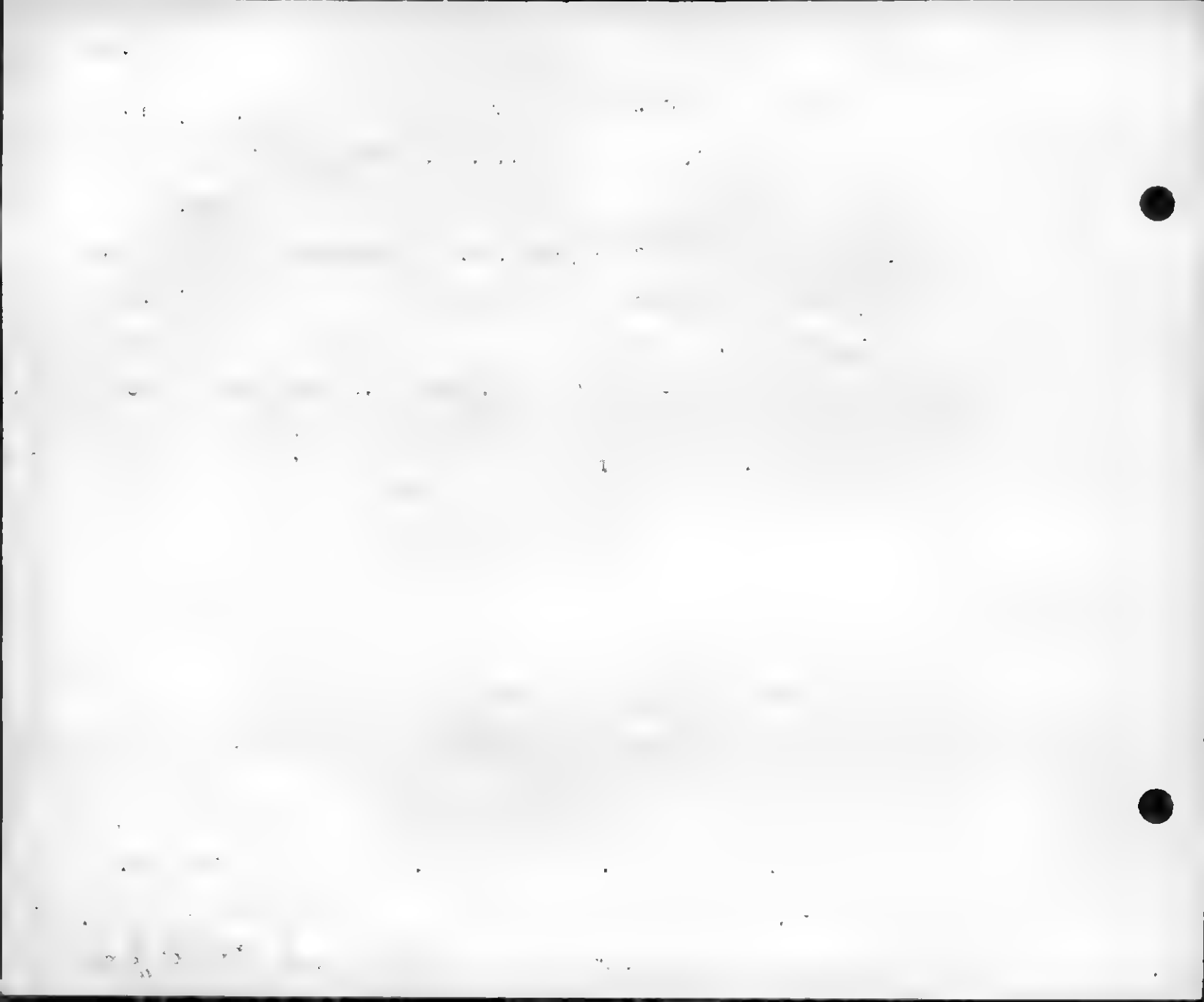
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
Elizabeth			W. Shreeves			Month Day Year			2:00 a.m.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS	7 UNDER 24 HRS HOURS	2c DATE PRONOUNCED DEAD			3:00 a.m.
Female	Negro	Mar. 15, 1920	48 YRS			Month Day Year			19 68
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		USA				Somerset Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Marion						Laborer			Seafood
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Md.			Som.			Marion			Box 162
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Chancil R. Whittington				Carrie S. Cottman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
No				220-09-1060		James Whittington Box 162 Marion, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma with generalized metastasis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				19					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>C. G. Rawley.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) C. G. Rawley, M.D.						22b DATE SIGNED		12/13/68	
						ADDRESS (Street, city, town or county)		Crisfield, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		12/13/68		Family Cemetery		Marion Som. Md.			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Anthony E. Ward				Crisfield, Md.		DATE DEC 18 1968		J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>18295</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>18308</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>																
1. DECEASED-NAME (Type or print)			First <b>NELLIE</b>			Middle <b>ADELE</b>			Last <b>TODD</b>			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR AM <b>M</b>	
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Oct. 31, 1886</b>			6. AGE (In years last birthday) <b>82</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Somerset</b> Md.							
10. CITY OR TOWN OF DEATH <b>Crisfield</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>34 Maryland Ave.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>							
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Somerset</b>			13c. CITY OR TOWN <b>Crisfield</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>34 Maryland Ave.</b>				
14. FATHER'S NAME First <b>William</b> Middle <b>W.</b> Last <b>Parks</b>			15. MOTHER'S MAIDEN NAME First <b>Rosina</b> Middle <b>-</b> Last <b>McCoy</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>215-44-6474</b>			17. INFORMANT Address <b>I. T. Todd, Jr., Hall Highway, Crisfield, Md.</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio. Vascular Accident</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Left Hemiparesis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 28, 1968</b> to <b>Dec. 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Sarah M. Peyton</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>12/31/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M. D.</b>			22e. ADDRESS <b>33 W. Main St., Crisfield, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec. 30, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Somerset, Md.</b>							
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons, Crisfield, Md. 21817</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, on or within 72 hours after death.

VR 415  
45M - 1968

18296

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

18309

1. DECEASED-NAME (Type or print) <b>John W. Ward</b>			2a. DATE OF DEATH <b>12/19/68</b> Month Day Year		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>April 18, 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Somerset</b> Md.	
10. CITY OR TOWN OF DEATH <b>Crisfield</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>McCready Memo.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Restaurant Owner</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>		13b. COUNTY <b>Mathews</b>	13c. CITY OR TOWN <b>Mathews</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Box 35</b>
14. FATHER'S NAME First Middle Last <b>Samuel T. Ward</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Etta Pruitt</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>158-09-7002</b>		17. INFORMANT Address <b>Mrs. Ruth Ward, Same as 13. abcde</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial Pneumonia</b> <b>422X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myocarditis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterial Vascular Accident</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 weeks</b> <b>5 mos.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>431X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased on <b>12/19/68</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C. N. Barr</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/20/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>A. N. Barr, M.D.</b>		22e. ADDRESS <b>Crisfield, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec 22, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Somerset, Md.</b>					
24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons, Crisfield, Md. 21817</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 27 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1000

1000

1000



1000

1000

1000

1000

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1/10/69 ts DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 11 Film G408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18310

1. DECEASED-NAME (Type or Print) First Middle Last <b>Preston 18297 Wise</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>Dec. 28 1968</b>		2b. HOUR <b>11:30</b>	
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>Nov. 15 1916</b>	6. AGE (in years last birthday) YRS. <b>52</b>	IF UNDER 1 YEAR MONTHS DAYS <b>52</b>	IF UNDER 24 HRS. HOURS MIN. <b>52</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Princess Anne</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bozman's 1300 St. Rt. 362</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Worcester</b>		13c. CITY OR TOWN <b>Pocomoke</b>	
14. FATHER'S NAME First Middle Last <b>Edward Wise</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Lee Collins</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>215-20-4795</b>		17. INFORMANT <b>Virginia Wise</b>		ADDRESS <b>Rt. 3 Pocomoke Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lower Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Influenza</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-4 days</b> <b>1 week</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>480X</b>					
19a. DATE OF OPERATION <b>480X</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Everett Sutter</b>		EXAMINER'S NAME (Type) <b>Everett Sutter</b>		22b. DATE SIGNED <b>1-3-68</b> <b>Somerset</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-4-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wardtown Cem.</b>	
24. FUNERAL DIRECTOR <b>Samuel Lee</b>		ADDRESS <b>New Church, Va.</b>		25. REC'D BY REGISTRAR <b>JAN 7 1969</b>	
26. REGISTRAR'S SIGNATURE <b>Samuel Lee</b>		27. REGISTRAR'S SIGNATURE <b>Samuel Lee</b>			

